PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			01 - MAIN BUILDING 01		PLETED
						1	R
		445234	B, WING		*	10/	09/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{K 000}	10/09/18 for all pre 08/20/18. All defici and no new non co	t survey was conducted on vious deficiencies cited on encies have been corrected, mpliance was found. The ince with all regulations	{K 0	00}			
							(Y6) DATE
LABORATORY	' DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	INATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 445234 08/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD GLEN OAKS HEALTH AND REHABILITATION SHELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 08/20/2018. During this Life Safety Survey, Glen Oaks Health and Rehabilitation was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). K 227 K 227 K 227 Ramps and Other Exits SS=D CFR(s): NFPA 101 SS=D Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, CFR(s): NFPA 101 alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12The facility will maintain the discharge 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 free of obstructions 1) The ramp outside of the 200 B-Hall emergency egress doors This REQUIREMENT is not met as evidenced was fitted with handrails on 9/27/18 by facility maintenance Based on observations, the facility failed to maintain the discharge free of obstructions. staff. 2) Ramps outside of other The findings include emergency egress doors were Observation on 08/20/2018 at 12:32 PM_revealed audited for compliance on the ramp outside of the 200 B-Hall emergency 8/20/18 by facility maintenance egress doors had a rise greater than 6 inches staff any issues found were TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE.

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation:

- 1. Observation on 08/20/2018 between 12:33 PM and 1:30 PM, revealed push carts stored in the corridor in the following areas.
- a. outside of room B15 (med cart)
- b. outside of room 19 (linen cart)
- c. outside of room 4 (linen cart)
- d. outside of room A7 (linen cart)

NFPA 101, 19 2 3 4 (2012 Edition)

2. Observation on 08/20/2018 at 12:42 PM

DEPAR ⁻	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 09/05/20 FORM APPROV	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03	91
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		PLE CONSTRUCTION (X3) DATE SURVEY IG 01 - MAIN BUILDING 01 COMPLETED	
		445234	B WING		08/20/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
GLEN O	AKS HEALTH AND RE	HABILITATION			1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	-IX	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	NC
					4 weeks, 2 times a week for 4	
K 227	Continued From pa	ge 1	K 2	227	7 weeks, 1 time a week for 4	
		ches) without hand rails or			weeks and 1 time a month for 1	
	guards on both side				month.	
	7.2.5.4.2 (2012 Edit	.1 (2012 Edition) NFPA 101,			4) The Administrator will report	
	7.2.0 1.2 (2012 2011				findings of the audits monthly	
		irector was present for the			to the QAPI committee for	
		were acknowledged by the the exit conference on			follow up and	
3	08/20/2018	, the extension on			recommendations as needed	
	Aisle, Corridor, or R CFR(s): NFPA 101	amp Width	K 2	232		
	unobstructed) servir least 4 feet and mai convenient removal stretchers, except a exceptions 1-5 19.2.3.4, 19.2.3.5 This REQUIREMEN by: Based on observation maintain Aisle, Corrional Time findings include 1 Observation on 06 and 1.30 PM reveal a outside of room B b outside of room 1	or corridors (clear or ing as exit access shall be at intained to provide the of nonambulatory patients on is modified by 19.2,3.4. IT is not met as evidenced ons, the facility failed to dor or Ramp Width. 8/20/2018 between 12.33 PM ed push carts stored in the incommodified art. 15 (med cart) 9 (linen cart)				
	c outside of room 4					
	VET 1 102 4					

2 Observation on 06/20/2016 at 12 42 PM

	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPLETED
		445234	B. WING		08/20/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 227	guards on both side NFPA 101, 19.2.2.6 7.2.5.4.2 (2012 Edit The maintenance d findings which later administrator during	ches) without hand rails or es of the ramp. .1 (2012 Edition) NFPA 101,	K 227	for 3 months. The QAPI committee consist of Medic Director, Administrator, DO Unit Managers, Wound Nur Infection Preventionist, Resident Financial Coordina Human Resources, Admissio Medical Records, Social	N, se/ itor,
	least 4 feet and mai convenient removal stretchers, except a exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMEN	amp Width	K 232		
	maintain Aisle, Corri The findings include 1, Observation on 08 and 1:30 PM, reveal corridor in the follow a outside of room 1 c. outside of room 4 d. outside of room A NFPA 101, 19-2 3.4	B/20/2018 between 12:33 PM ed push carts stored in the ing areas 15 (med cart) 9 (linen cart) (linen cart) 7 (linen cart)			

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

CLIAIL	TO FOR MILDIOMINE	A MILDIOMID OLIMIOLO					1 5.5	
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ ' '		E CONSTE D1 - MAIN	RUCTION I BUILDING 01		ATE SURVEY OMPLETED
		445234	B WING				08	8/20/2018
NAME OF	PROVIDER OR SUPPLIER			S7	TREET AD	DRESS, CITY, STATE, ZIP CODE		
GLEN O	AKS HEALTH AND RE	EHABILITATION				NOAKS ROAD		
				S	HELBAY	VILLE, TN 37160	+===	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
						Services, Plant Operations		
K 227	Continued From pa	-	K:	227		Manager, Activities and Diet	tary.	
		iches) without hand rails or					,	
	guards on both side	es of the ramp. 5.1 (2012 Edition) NFPA 101,						9/27/18
	7.2.5.4.2 (2012 Edi							3/2//10
	The maintenance of	lirector was present for the						
	0	were acknowledged by the						
	administrator during 08/20/2018	g the exit conference on						
	Aisle, Corridor, or F	Ramp Width	K 2	232	K 232			
SS=E	CFR(s): NFPA 101				SS=E			
	Aisle, Corridor or R	amp Width			Aisle,	Corridor or Ramp Width		
	2012 EXISTING				T1 - C-	-titetill avalatain oido		
		or corridors (clear or				icility will maintain aisle,		
		ng as exit access shall be at intained to provide the			corrid	or and ramp width.		
	convenient remova	of nonambulatory patients on			1)	a. The med cart outside of		
		as modified by 19.2.3 4			,	room B 15 was moved on		
	exceptions 1-5					8/20/18 by facility staff		
	19.2 3 4, 19.2 3 5 This REQUIREMEN	NT is not met as evidenced				b. The linen cart outside of		
	by	vi la natimat de endeme				room 19 was moved on		
		ions, the facility failed to						
	maintain Aisle, Corr	idor or Ramp Width				8/20/18 by facility staff	_	
	The findings include					c. The linen cart outside roc	m 4	
	The mange molace					was moved on 8/20/18 by		
	1 Observation on 0	8/20/2018 between 12 33 PM				facility staff.		
		led push carts stored in the				d. The linen cart outside of		
	contide in the falloy a butside of room B					room A7 was moved on		
	b outside of room 1					8/20/18 by facility staff.		
	c outside of room 4				21	The ramp outside of 200 B I	Hall	
	a putside of room 4				۷,	•		
	The Later -	Zur Dan				emergency egress doors wa	13	
	The Time	puntuntas as en an tika				widened to at least 48" on		
	Z Observation on u	8/20/2016 at 12 42 PM				9/19/18 by facility mainten	ance	

08/20/2018

SS=D CFR(s) NFPA 101

a. 02/2017 through 06/2017 b. 03/2018 through 08/2018

7.9 3 1 (2012 Edition)

NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101,

The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on

K 761 Maintenance, Inspection & Testing - Doors

K 761

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		- MAIN BUILDING 01			E SURVEY IPLETED
		445234	B WING				08/	20/2018
,,,,,,,	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		1101	EET ADDRESS, CITY, STATE, ZIF 1 GLEN OAKS ROAD ELBYVILLE, TN 37160	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROP!	BE	(X5) COMPLETION DATE
	egress doors of 200 its narrowest width inches). NFPA 101, The maintenance d findings which later	outside of the emergency B-Hall was 42 inches wide at (minimum required width 48 19.2.3.4* (2012 Edition) irector was present for the were acknowledged by the gather than the conference on	K 2		egress doors were facility maintenand proper width on 8, any issues were ad 4) Facility maintenan in-serviced on 8/20 Administrator on k path of egress clea	ce staff fo /20/18 an Idressed. ce staff w 0/18 by keeping th	r d as	
SS=D	CFR(s): NFPA 101 Emergency Lighting Emergency lighting is provided automat 18.2.9.1, 19.2.9.1 This REQUIREMEN by: Based on documer maintain the emerge The findings include Document review or AM and 12:13 PM, the provide documentate emergency light test a. 02/2017 through the 03/2018 through NFPA 101, 19.2.9 1 The maintenance difindings which later administrator during 08/20/2018	of at least 1-1/2-hour duration ically in accordance with 7.9. IT is not met as evidenced at review the facility failed to ency lighting on 08/20/2018 between 11:00 revealed the facility failed to ion for the monthly to for the following months 06/2017 08/2018 (2012 Edition) NEPA 101 rector was present for the were acknowledged by the the exit conference on				## Company of the Com		
in agra	Maintenance inspe	ough fillesting Dinord						

CENTER	42 LOK MEDICAKE	E & MEDICAID SERVICES				JIVID INO.	. 0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION - MAIN BUILDING 01		E SURVEY IPLETED
		445234	B. WING			08/	20/2018
NAME OF I	PROVIDER OR SUPPLIER	,			EET ADDRESS, CITY, STATE, ZIP CODE		
GLEN O	AKS HEALTH AND RE	EHABILITATION			1 GLEN OAKS ROAD ELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
					initiated by nurse educator	on	
K 232	Continued From pa	age 2	K 2	232	8/22/18 on keeping the pat	h of	
		outside of the emergency			egress clear. Compliance w	/ill	
		0 B-Hall was 42 inches wide at (minimum required width 48			be monitored for during da	ily	
		, 19.2.3.4* (2012 Edition)			facility rounds by departme	nt	
	,				head staff 5 times a week fo	or 4	
		director was present for the			weeks, 2 times a week for 4	ļ	
		were acknowledged by the g the exit conference on			weeks and 1 time a week fo	or 4	
	08/20/2018	9			weeks and 1 time a month	for 1	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101	g	K 2	291			
	is provided automa 18.2.9.1, 19.2.9.1 This REQUIREMED by:	of at least 1-1/2-hour duration tically in accordance with 7.9. NT is not met as evidenced on review the facility failed to					
	The findings include	e ·					
	AM and 12:13 PM, provide documenta emergency light tes a. 02/2017 through b 03/2018 through	08/2018 (2012 Edition) NFPA 101					
	findings which later administrator during 58/20/29 8	lirector was present for the were acknowledged by the parties the exit conference on			.4		
i• i i j (€) ± (* :	Maintenance inspendence of the MERICAL MERICAL DE	ection it Testing Doors	Y.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01		ATE SURVEY OMPLETED
		445234	B WING)		0:	8/20/2018
	PROVIDER OR SUPPLIER	EHABILITATION		1101	EET ADDRESS, CITY, STATE, ZIP CODE GLEN OAKS ROAD ELBYVILLE, TN 37160	TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 232 K 291 SS=D	egress doors of 20 its narrowest width inches). NFPA 101 The maintenance of findings which later	outside of the emergency 0 B-Hall was 42 inches wide at (minimum required width 48 , 19.2.3.4* (2012 Edition) director was present for the r were acknowledged by the g the exit conference on		232	month. 5) 4. The Administrator will findings of the audits months to the QAPI committee for follow up and recommendations as new for 3 months. The QAPI committee consist of Medical Director, Administrator,	enthly or eded	
	is provided automa 18.2.9.1, 19.2.9.1 This REQUIREME by:	of at least 1-1/2-hour duration atically in accordance with 7.9. NT is not met as evidenced and review the facility failed to					
	AM and 12:13 PM, provide documents emergency light te a 02/2017 through b 03/2018 through	on 08/20/2018 between 11:00 revealed the facility failed to ation for the monthly st for the following months: 06/2017 08/2018					
	findings which late administrator durin 08/20/2018	director was present for the rwere acknowledged by the g the exit conference on ection & Testing - Doors	К	761	3		

FORM CMS 2567(92 99) Previous Versions Obsolete

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A: BUILDING 01 - MAIN BUILDING 01				ATE SURVEY OMPLETED
		445234	B WING			0	8/20/2018
	PROVIDER OR SUPPLIER	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 291	egress doors of 20 its narrowest width inches). NFPA 101 The maintenance of findings which later administrator durin 08/20/2018 Emergency Lightin CFR(s): NFPA 101 Emergency Lightin Emergency lighting is provided automata. 2.9.1, 19.2.9.1 This REQUIREME by: Based on docume maintain the emergency lighting is provided automata. 2.9.1, 19.2.9.1 The findings included Document review of AM and 12:13 PM, provide documentate emergency light test a. 02/2017 through b. 03/2018 through NFPA 101, 19.2.9.7 7.9.3.1 (2012 Edition The maintenance of the maintenance of the same provide documentate and the same provide documentate and 2.12012 Edition The maintenance of the maintenance of the same provide documentate and 2.12012 Edition The maintenance of the same provide documentate and 2.12012 Edition The maintenance of the same provided and 2.12012 Edition The same provided and 2.12012 Edition The same	outside of the emergency 0 B-Hall was 42 inches wide at (minimum required width 48, 19.2.3.4* (2012 Edition) director was present for the rewere acknowledged by the general the exit conference on general g	K 2	91 K 291 SS=D Emerg CFR(s)	Facility maintenance star completed testing of emergency lighting on 8 and documented a test of emergency lighting on 8 as scheduled thru TELS preventative maintenant programs.	etary. etary. ff /20/18 of the /31/18 ce ff was histrator	9/27/18
K 761	administrator durin 08/20/2018	r were acknowledged by the g the exit conference on ection & Testing - Doors	K . 7	61	documentation of mont	_	

SS=0 CFR(s) NFPA 101

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 08/20/2018 B. WING 445234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 GLEN OAKS ROAD GLEN OAKS HEALTH AND REHABILITATION SHELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 232 K 232 Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on emergency lighting checks and 08/20/2018 K 291 K 291 Emergency Lighting entering it into the TELS system. SS=D | CFR(s): NFPA 101 Compliance will be monitored by the administrator by using **Emergency Lighting** Emergency lighting of at least 1-1/2-hour duration the monthly TELS reports for 3 is provided automatically in accordance with 7,9, months. 18.2.9.1. 19.2.9.1 3) The Administrator will report This REQUIREMENT is not met as evidenced findings of the audits monthly Based on document review the facility failed to to the QAPI committee for maintain the emergency lighting. follow up and The findings include: recommendations as needed for 3 months. The QAPI Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to committee consist of Medical provide documentation for the monthly Director, Administrator, DON, emergency light test for the following months: Unit Managers, Wound Nurse/ a. 02/2017 through 06/2017 Infection Preventionist, b 03/2018 through 08/2018 NFPA 101, 19 2.9 1 (2012 Edition) NFPA 101, Resident Financial Coordinator, 7 9 3 1 (2012 Edition) Human Resources, Admissions, Medical Records, Social The maintenance director was present for the findings which later were acknowledged by the Services, Plant Operations administrator during the exit conference on Manager, Activities and Dietary. 9/27/18 08/20/2018 K 761 K 761 K 761 Maintenance, Inspection & Testing Doors SS=D CFR(s): NFPA 101 SS=D

O	13 I OK MEDICAKE	& MEDICAID SERVICES			DIVID IVO	1, 0930-039
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		445234	B WING_	A	08	/20/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD		
GLEN O	AKS HEALTH AND RE	HABILITATION		SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BÉ	(X5) COMPLETION DATE
K 761	Continued From pa	ge 3	K 76	Maintenance, Inspection & Testin Doors	ng –	1
	Fire doors assemble annually in accordation for Fire Doors and a Non-rated doors, in patient rooms and a routinely inspected maintenance programates in the properties of the patient records of its maintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NF This REQUIREMENT)	ing the door inspections and by		The facility will maintain the open protectives. 1) The fire/ smoke dampers inspected by the Simplex Grinnell on 9/6/18. 2) Administrator in-serviced facility maintenance staff 8/20/18 to ensure the red 4 year damper inspection completed. 3) Facility maintenance staff monitor for documentatic compliance monthly for 3 months through TELS rep	on quired is	
	AM and 12:13 PM, provide documenta dampers within the NFPA 101, 8.2.2.4 (19.4.1.1 (2010 Edition The maintenance of findings which later administrator during 08/20/2018	2012 Édition), NFPA 80, on) irector was present for the were acknowledged by the public the exit conference on		4) The Administrator will refindings of the audits moto to the QAPI committee for follow up and recommendations as need for 3 months. The QAPI committee consist of Medical Director, Administrator, Education of the Committee consist of Medical Director, Administrator, Education of the Committee consist of Medical Director, Administrator, Education of the Committee Consist of Medical Director, Administrator, Education of the Committee Consist of Medical Director, Administrator, Education of the Committee Consist of the Committee Consist of the Committee Committe	nthly r ded dical	
	Electrical Systems - CFR(s), NFPA 101	Essential Electric Syste	K 91	8		
	Electrical Systems -	Essential Electric System				

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			CIVID IVC	. 0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		445234	B WING			/20/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GLEN OA	KS HEALTH AND RE	EHABILITATION		1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 761 i	Fire doors assemb annually in accorda for Fire Doors and Non-rated doors, ir patient rooms and routinely inspected maintenance progr Individuals perform testing possess kn that demonstrates Written records of maintained and are 19.7.6, 8.3.3.1 (LS 5.2, 5.2.3 (2010 NF This REQUIREME by:	ection & Testing - Doors lies are inspected and tested ance with NFPA 80, Standard Other Opening Protectives. Including corridor doors to smoke barrier doors, are as part of the facility Itam. Itaming the door inspections and owledge, training or experience ability. Inspection and testing are e available for review. C)	K 7	Unit Managers, Wound Infection Preventionist, Resident Financial Coor Human Resources, Adm Medical Records, Social Services, Plant Operatio Manager, Activities and	dinator, nissions, ons	9/27/18
	AM and 12:13 PM,					
	The maintenance of findings which late	(2012 Édition), NFPA 80,				*
K 918 SS=D	CFR(s): NFPA 101		ΚS	K 918 SS=D Electrical Systems – Essential Systems Maintenance and Te	Electric	
	Electrical Systems	- Essential Electric System		Systems ivialities and vi		

Event ID 6R5Q21

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		445234	B: WING		08/	20/2018
	(EACH DEFICIENC)	EHABILITATION ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 918	and associated equipments in a service within 10 secriterion is not met process shall be procapability for the life Maintenance and to transfer switches a with NFPA 110. Generator sets are under load 30 minuted and 30 minuted and intervals, and a months for 4 continuated cold startransfer of all EES competent personn stored energy power accordance with NF circuit breakers are program for periodic components is estamanufacturer requimaintenance and to the possibility of das source is a design of installations 6.4.4, 6.5.4, 6.6.4 (installations 6.4.4, 6.5.4, 6.6.4 (insta	esting other alternate power source sipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this esafety and critical branches. esting of the generator and reperformed in accordance inspected weekly, exercised ates 12 times a year in 20-40 exercised once every 36 events and automatic or manual loads, and are conducted by sel. Maintenance and testing of er sources (Type 3 EES) are in EPA 111 Main and feeder inspected annually, and a cally exercising the ablished according to rements. Written records of esting are maintained and ES electrical panels and readily identifiable, and hall power circuits. Minimizing mage of the emergency power consideration for new NEPA 99), NEPA 110, NEPA 70) NT is not met as evidenced and review the facility failed to	K 918	The facility will maintain the general 1) On 8/21/18 Taylor Power Services came and reset the timing on the generator to for 30 minutes under full lowith a 15 minute cool down facility maintenance staff of 8/20/18 regarding the requirement to run the generator under full load for the full 30 minutes monthles and test thru TELS reports log inspection. The Administrator will monitor compliance monthly for 3 months thru the TELS reports log inspection. The Administrator will monitor compliance monthly for 3 months thru the TELS reports log inspection. The Administrator will report system. 4) The Administrator will report findings of the audits monitor to the QAPI committee for follow up and recommendations as need for 3 months. The QAPI committee consist of Meditageneral commi	e run oad n. ced on or ly. will ator and orting ort thly	

The findings include:

Facility ID TN0202

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445234	B WING		08/20/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND R SUMMARY ST.	ATEMENT OF DEFICIENCIES	11 S	REET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD HELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	
PREFIX	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
K 918	AM and 12:13 PM, exercise the gener minutes monthly. NFPA 101, 19.5.1.	age 5 on 08/20/2018 between 11:00 revealed the facility failed to rator under a load for 30 1 (2012 Edition), NFPA 101, on), NFPA 110, 8,4.2 (2010	K 918	Director, Administrator, DO Unit Managers, Wound Nur Infection Preventionist, Resident Financial Coordina Human Resources, Admissi Medical Records, Social Services, Plant Operations	ator, ons,
K 920 SS=D	findings which late administrator durir 08/20/2018	director was present for the r were acknowledged by the g the exit conference on ent - Power Cords and Extens	K 920	Manager, Activities and Die K 920 SS=D	9/27/1
	Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble by qualified persor 10.2.3.6. Power smay not be used felectronics), exceptooms that do not PCREE meet UL strips for non-PCF (outside of vicinity care rooms, powe standards. All powers and powers an	ent - Power Cords and natient care vicinity are only ints of movable d electrical equipment es that have been assembled inel and meet the conditions of trips in the patient care vicinity or non-PCREE (e.g., personal of in long-term care resident use PCREE. Power strips for 1363A or UL 60601-1. Power IEE in the patient care rooms in meet UL 1363. In non-patient or strips meet other UL iver strips are used with general insion cords are not used as a wiring of a structure ised temporarily are removed completion of the purpose for illed and meets the conditions of		Electrical Equipment – Power Corr Extension Cords CFR(s): NFPA 101 The facility will properly use power cords. 1) a. The power strip in room was removed 8/20/18 and replaced with the appropertype. b. The power strip in room was removed 8/20/18 and replaced with the appropertype. c. The power strip in room was removed on 8/20/20 replaced with the appropriate was removed with the appropriate was removed on 8/20/20 replaced with the appropriate was removed with the appropriate was removed with the appropriate was removed was removed on 8/20/20 replaced with the appropriate was removed was removed on 8/20/20 replaced with the appropriate was removed was	er m B 15 d riate m A 40 d riate n A 4 l8 and

Facility ID TN0202

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					JIVID IVO	0930-038
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		ONSTRU - MAIN E	ICTION BUILDING 01	(X3) DATE SURVEY COMPLETED	
		445234	B_ WING				08/	20/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDF	RESS, CITY, STATE, ZIP CODE		
				110	1 GLEN C	DAKS ROAD		
GLEN OA	AKS HEALTH AND R	EHABILITATION		SHI	ELBYVII	LLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EA	PROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO DEFICIENCY)	D BÉ	(X5) COMPLETION DATE
				Î		type.		
	Continued From pa	age 6	K S	920	2)	The facility maintenance	staff	
	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8					audited resident rooms	to	
		D) (NFPA 70), TIA 12-5				ensure that power strips	are	1
		NT is not met as evidenced				being used for the appro		
	by:	ant review the facility failed to				-		
	properly power cor	ent review the facility failed to	P			purpose on 8/20/18 any		
	property power cor	40				identified were immedia	ately	
1	The findings includ	le:				corrected.		i i
	_		i I		3)	The Administrator in -se	erviced	
	_	8/20/2018 between 12:32 PM			-,	facility maintenance sta		ît
	•	aled power adapters not listed						
		the following areas:				8/20/18 on the appropr		
		M B15 (1363A with personal equipment) M A 40 (1363A with personal equipment)				type and usage of powe		
		3A with personal equipment)				Nurse educator initiated	d in-	
	0. 141/17 (1000/11	man percental equipments				servicing facility staff or	1	
	The maintenance	director was present for the				8/22/18 regarding the		
		r were acknowledged by the				appropriate type and us	age of	
		ig the exit conference on				• • •		
	08/20/2018		12	000		power strips. The facili	ty wiii	
K 923	Gas Equipment - C CFR(s): NFPA 101	Cylinder and Container Storag	K!	923				
		Cylinder and Container Storage						
		ual to 3,000 cubic feet						
		are designed, constructed, and						
		dance with 5.1.3.3.2 and						
	5.1.3.3.3. >300 but <3,000 ci	uhic feet						
		are outdoors in an enclosure or						
		interior space of non- or						
		le construction, with door (or						
		at can be secured. Oxidizing						
		ed with flammables, and are						
		mbustibles by 20 feet (5 feet if						
		closed in a cabinet of						
		onstruction having a minimum						
	1/2 hr fire protection	on raung						

Facility ID TN0202

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTR 3 01 - MAIN	(X3) DATE SURVEY COMPLETED		
		445234	B_WING			08/	/20/2018
	PROVIDER OR SUPPLIER	EHABILITATION		1101 GLEN SHELBYV	ORESS, CITY, STATE, ZIP CODE OAKS ROAD ILLE, TN 37160		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD ISS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
2	(NFPA 70), 590.3(I This REQUIREME by: Based on docume properly power cor The findings include Observations on 0 and 1:28 PM, reve for the purpose in a. RM B15 (1363A) b. RM A 40 (1363A) c. RM A 4 (1363A) The maintenance findings which late administrator during 08/20/2018 Gas Equipment - 0 Gas Equipment - 0	N, 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 NT is not met as evidenced Intreview the facility failed to ds. Re: R/20/2018 between 12:32 PM aled power adapters not listed the following areas: with personal equipment) with personal equipment) with personal equipment) with personal equipment Cylinder and Container Storage	K 92	4)	monitor for compliance didaily rounds by department head staff 5 days a week for weeks 2 times a week for weeks 1 time a week for weeks and 1 time a mont month. The Administrator will refindings of the audits monto to the QAPI committee for follow up and recommendations as need for 3 months. The QAPI committee consist of Me Director, Administrator, I Unit Managers, Wound Nanet Infection Preventionist,	ent for 4 4 4 h for 1 port nthly or eded dical DON,	
	Storage locations ventilated in according 5.1.3.3.3. >300 but <3,000 constructions within an enclosed limited-combustib gates outdoors) the gases are not storage are not storage locations.	are outdoors in an enclosure or linterior space of non- or le construction, with door (or at can be secured. Dixidizing ed with flammables, and are imbustibles by 20 feet (5 feet if closed in a cabinet of postruction having a minimum					

Facility ID: TN0200

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445234	B WING		08/20/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND R	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	<
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	OF SECTION TO THE ARREST	OULD BE COMPLETION
	(NFPA 70), 590.3(This REQUIREME by:), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 ENT is not met as evidenced ent review the facility failed to	K 9	Resident Financial Coord Human Resources, Admi Medical Records, Social Services, Plant Operation Manager, Activities and	ssions,
	and 1:28 PM, reversor for the purpose in a. RM B15 (1363A b. RM A 40 (1363A c. RM A 4 (1363A). The maintenance findings which late administrator during	de: 8/20/2018 between 12:32 PM caled power adapters not listed the following areas: with personal equipment) with personal equipment) with personal equipment) director was present for the er were acknowledged by the ing the exit conference on			
K 923 SS=D	Gas Equipment - Greater than or ec Storage locations ventilated in accor 5.1.3.3.3. >300 but <3,000 c Storage locations within an enclosed limited- combustit gates outdoors) th gases are not stor separated from co sprinklered) or en	Cylinder and Container Storage qual to 3,000 cubic feet are designed, constructed, and dance with 5.1,3,3,2 and cubic feet are outdoors in an enclosure or dinterior space of non- or ole construction, with door (or not can be secured. Oxidizing red with flammables, and are ombustibles by 20 feet (5 feet if closed in a cabinet of onstruction having a minimum.		SS=D Gas Equipment – Cylinder and Container Storage CFR(s): NFPA 101 The facility will properly store of cylinders. 1) Facility maintenance store constructed an enclose around the O2 cylinder 08/30/18. 2) Administrator in-service	taff ure rs on

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 08/20/2018 445234 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 GLEN OAKS ROAD GLEN OAKS HEALTH AND REHABILITATION SHELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) facility maintenance staff on K 923 K 923 | Continued From page 7 properly storing oxygen Less than or equal to 300 cubic feet cylinders on 8/20/18. The In a single smoke compartment, individual Nurse Educator initiated an incylinders available for immediate use in patient care areas with an aggregate volume of less than service on 8/30/18 for facility or equal to 300 cubic feet are not required to be staff. The facility will monitor stored in an enclosure. Cylinders must be for compliance by doing weekly handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on audits for 4 weeks and monthly each door or gate of a cylinder storage room, audits for 3 months. where the sign includes the wording as a 3) The Administrator will report minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." findings of the audits monthly Storage is planned so cylinders are used in order to the QAPI committee for of which they are received from the supplier. follow up and Empty cylinders are segregated from full cylinders. When facility employs cylinders with recommendations as needed integral pressure gauge, a threshold pressure for 3 months. The QAPI considered empty is established. Empty cylinders committee consist of Medical are marked to avoid confusion. Cylinders stored in the open are protected from weather. Director, Administrator, DON, 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Unit Managers, Wound Nurse, This REQUIREMENT is not met as evidenced Resident Financial Coordinator, Based on document review the facility failed to Human Resources, Admissions, properly store oxygen cylinders. Medical Records, Social Services, Plant Operations The findings include: Manager, Activities and Dietary. Document review on 08/20/2018 at 12:13 AM, 9/27/18 revealed oxygen bottles not secured from unauthoized access under the rear canopy by maintenance NFPA 99, 11.6.2.3 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on

08/20/2018

PRINTED: 10/11/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445234	B. WING			l .	≺ 09/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 000}	conducted by the S of Health Division of Regulation Office of on 08/20/2018. Du Preparedness Surv Rehabilitation Cent compliance with the in Emergency Prep Long-Term Care Fa The requirement at MET as evidenced	paredness Survey was tate of Tennessee Department of Health Licensure and f Health Care Facilities survey ring this Emergency rey, Glen Oaks Health and er was not found in substantial erequirements for participation aredness Regulations for acilities, Federal CFR §483.73. 142 CFR, §483.73 are NOT by:	{E 00	00}	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTER	49 I OIL MILDICAILE	A MEDICAID SERVICES				1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445234	B. WING			08	/20/2018
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION	1	101 GLEN	DRESS, CITY, STATE, ZIP CODE OAKS ROAD (ILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000				
	conducted by the S of Health Division of Regulation Office of on 08/20/2018. Du Preparedness Surv Rehabilitation Cent compliance with the in Emergency Prep Long-Term Care Fa	paredness Survey was tate of Tennessee Department of Health Licensure and f Health Care Facilities survey ring this Emergency ey, Glen Oaks Health and er was not found in substantial er requirements for participation aredness Regulations for acilities, Federal CFR §483,73.					
	MET as evidenced Plan Based on All F CFR(s): 483,73(a)(d on All Hazards Risk Assessment			ised On All Hazards Risk		
	and maintain an en that must be review	nergency preparedness plan ved, and updated at least must do the following:]		Assessr CFR(s):	483.73(a)(1)-(2)		
	facility-based and c assessment, utilizing	d include a documented, community-based risking an all-hazards approach.*			cility will complete the risk ment utilizing an all-hazards ch	à	
	on and include a do community-based r	at §483,73(a)(1):] (1) Be based ocumented, facility-based and risk assessment, utilizing an characteristic moduling missing residents		1)	The facility maintenance st completed another risk assessment utilizing an all-		
	and include a docu community-based r	83 475(a)(1)*] (1) Be based on mented, facility-based and isk assessment, utilizing an chaincluding missing clients.		2)	hazards approach on 9/17/ The facility will review the assessment and adopt upd Disaster Preparedness Plan	lated	
	(2) Include strateg	es for addressing emergency			9/21/18 during the QAPI		(VC) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	(X3)	(X3) DATE SURVEY COMPLETED		
		445234	B. WING				08/20/2018
	(EACH DEFICIENCY	EHABILITATION TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1101 GLE SHELBY	DDRESS, CITY, STATE, ZIP NOAKS ROAD VILLE, TN 37160 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION N SHOULD BE E APPROPRIAT	(X5) COMPLETION E DATE
E 015	* [For Hospices at § strategies for addre identified by the risk management of the failures, natural dist that would affect the care. This REQUIREMENT by: Based on interview complete the risk at all-hazards approace Federal CFR §483. The finding included Interview on 08/20/22:40 PM, revealed the documentation of the based risk assessm preparedness programment of the second risk assessment of the secon	the risk assessment. (3418.113(a)(2):] (2) Include ssing emergency events assessment, including the consequences of power asters, and other emergencies is hospice's ability to provide. It is not met as evidenced as, the facility failed to assessment utilizing an other per the requirements of a consequence of the facility failed to maintain the facility failed to maintain the facility based/community then for the emergency fam.	ΕO	4	meeting. Administrator in-s facility maintenant 8/20/18 on maint complete all hazar assessment in the Preparedness Plan facility will monito compliance by rev disaster plan mon our QAPI meeting The Administrator findings of the aud to the QAPI comm follow up and recommendations for 3 months. The committee consist Director, Administ Unit Managers, W Infection Preventic Resident Financial	nce staff on aining the rds facility rise Emergency in Binder. The proof of the thly during its. If will report dits monthly intee for sas needed a QAPI to f Medical trator, DON, Yound Nurse onist,	e /
	policies and proced plan set forth in para assessment at para and the communica this section. The po	ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually.] At a					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445234	B. WING		08/20/2018	
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD HELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE COMPLETION	
E 006	* [For Hospices at § strategies for addre identified by the risk management of the failures, natural disathat would affect the care. This REQUIREMENT by: Based on interview complete the risk as	the risk assessment. [3418.113(a)(2):] (2) Include ssing emergency events assessment, including the consequences of power asters, and other emergencies is hospice's ability to provide enter the facility failed to assessment utilizing another per the requirements of	E 006	Human Resources, Admission Medical Records, Social Services, Plant Operations Manager, Activities and Dieta		
	2:40 PM, revealed the documentation of the based risk assessment at para and the communication of the based risk assessment at para and the based risk as a contraction of the based risk as a contraction of the based r	2018 between 1:55 PM and the facility failed to maintain the facility based/community ment for the emergency ram. rified by the administrator of the facility's emergency ram. for Staff and Patients	E 015	E 015 SS=D Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) The facility will include all policies a procedures for the subsistence need residents and staff in the emergence	ds of	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445234	B. WING	3	80	3/20/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	TION	(75)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	A THE STREET OF THE ADDR	ULD BE	(X5) COMPLETION DATE	
E 015	address the following and patients wheth place, include, but (i) Food, water, me supplies (ii) Alternate source following: (A) Temperature safety and for the sprovisions. (B) Emergency (C) Fire detection systems. (D) Sewage and *[For Inpatient Hose Policies and proce (6) The following a hospice-operated in The policies and proce (6) The following: (iii) The provision of hospice employees evacuate or shelted limited to the follow (A) Food, water, supplies. (B) Alternate sour following: (1) Temperature and safety and for of provisions. (2) Emergence (2) Emergence (2) Emergence (3) The source (4) Emergence (4) Emergence (5) Emergence (5) Emergence (6) Emergence (6) Emergence (7) Emergen	sies and procedures must ng: If subsistence needs for staff per they evacuate or shelter in are not limited to the following: edical and pharmaceutical es of energy to maintain the est to protect patient health and safe and sanitary storage of eighting in extinguishing, and alarm waste disposal. Inpice at §418.113(b)(6)(iii):] dures re additional requirements for inpatient care facilities only rocedures must address the end subsistence needs for and patients, whether they in place, include, but are not ving: medical, and pharmaceutical curces of energy to maintain the enes to protect patient health the safe and sanitary storage	E	preparedness program 1) The Administrator and of members of the QAPI committee developed a to address an alternate of energy to maintain temperatures to protect resident health, emerge lighting, fire detection, extinguishing and alarm systems and sewage and disposal on 9/21/18. 2) The QAPI committee will policy on 9/21/18 during Committee meeting. 3) Administrator in-service facility maintenance sta 8/20/18 on maintaining policy that addresses the alternate energy source Emergency Preparedness Binder. The facility will for compliance by review disaster plan monthly dour QAPI meetings. 4) The Administrator will refindings of the audits meto the QAPI committee follow up and recommendations as needs.	policy source cancy cance cancy cance canc		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445234	B. WING		08/20/2018
	PROVIDER OR SUPPLIER	EHABILITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD HELBYVILLE, TN 37160	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
E 015	This REQUIREME by: Based on record rinclude all policies subsistence needs emergency prepar. The findings include Interview on 08/20 2:40 PM, the facility procedures for alternaintain the follown a. Temperatures to be Emergency light	waste disposal. NT is not met as evidenced eviews, the facility failed to and procedures for the of residents and staff in the edness program. led: //2018 between 1:55 PM and y failed to provide policies and ernate sources of energy to ing: protect resident health ing xtinguishing, and alarm	E 015	for 3 months. The QAPI committee consist of Medica Director, Administrator, DON Unit Managers, Wound Nurs Infection Preventionist, Resident Financial Coordinat Human Resources, Admission Medical Records, Social Services, Plant Operations Manager, Activities and Diet	l, e/ or, ns,
E 020 SS=D	during the interview preparedness progressive policies for Evac. a CFR(s): 483.73(b) [(b) Policies and proceution proceution proceution process proceution process proceution process	and Primary/Alt. Comm. (3) rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ated at least annually. At a sies and procedures must	E 020	Policies for Evac. And Primary/ ALT Communication CFR(s): 483.73(b)(3) The facility will provide evacuation policies and procedures based on the emergency plan.	
	Safe evacuation fr	om the [facility], which includes		 The Administrator and othe members of the QAPI 	?r

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTR ING	(X3) DATE SURVEY COMPLETED		
		445234	B. WING			08	/20/2018
GLEN O	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION ATEMENT OF DEFICIENCIES	ID	1101 GLEN SHELBYV	ORESS, CITY, STATE, ZIP CODE OAKS ROAD FILLE, TN 37160 PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	χ (E,	ACH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
E 020	evacuees; staff residentification of evaprimary and alternation with external source *[For RNHCs at §4 §416.54(b)(2):] Safe evacuation from the includes the following (i) Consideration of (ii) Staff responsibilities. (iv) Identification of (v) Primary and alternation with assistance. * [For CORFs at §4 Rehabilitation Agernation from Safe evacuation from Rehabilitation Agernation Agernation and Safe evacuation from Rehabilitation Agernation and Safe evacuation from the staff responsibilities. * [For RHCs/FQHC evacuation from the appropriate placemone in the possibilities and This REQUIREME by: Based on interview	are and treatment needs of sponsibilities; transportation; acuation location(s); and ate means of communication es of assistance. 03.748(b)(3) and ASCs at something and the [RNHCI or ASC] which ing: for care needs of evacuees alities. Fevacuation location(s). Sernate means of the external sources of the external sources of the ERD Facilities at some the [CORF; Clinics, and ESRD Facilities at some the patients of the patients of the patients. Cos at §491.12(b)(1):] Safe the RHC/FQHC, which includes the exit signs, staff the needs of the patients. The source of the patients of the p	EC	2)	committee developed a on 9/21/18 to address s staff responsibilities and needs of the eyacuees of an evacuation. The QAPI committee will policy on 9/21/18 during Committee meeting. The Administrator in-ser the facility staff on 9/21 having a policy that add the specific responsibility staff and the needs of the evacuees during an evacuation. The facility will monitor compliance by reviewing disaster plan monthly do our QAPI meetings. The Administrator will refindings of the audits meeting to the QAPI committee follow up and recommendations as need for 3 months. The QAPI committee consist of Monitorial monitors, Administrator, Unit Managers, Wound Infection Preventionist, Resident Financial Coor Human Resources, Administrator, Administrator, Resident Financial Coor Human Resources, Administrator, Resident Financial Coor Human Resources, Administrator, Administrator, Resident Financial Coor Human Resources, Administrator, Resident Financial Coor H	pecific de the during ll adopt g QAPI viced /18 on resses ties of the cuation. for g the turing leport onthly for leeded leedical poon, Nurse/ dinator,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		445234	B, WING			08	20/2018
,	PROVIDER OR SUPPLIER	HABILITATION		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD HELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 020	Continued From page 5 The findings included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, the facility could not provide evacuation polices and procedures that included specific staff responsibilities and the needs of the evacuees during an evacuation.			020	Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.		
					Sec.		9/27/18
	during the interview preparedness prog	leans for Communication	ΕC		E 032 SS=D		
SS=D	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483,475(c):] (3) Primary and				Primary/ Alternate Means for Communication CFR(s): 483.73(c)(3) The facility will include policies and		
					procedures for primary and alternate means for communicating with facility staff, Federal, State, Tribal, regional and local emergency management agencies in the emergency preparedness program.		
2	ICF/IID's staff, Fed- local emergency m This REQUIREMED by: Based on interview policies and proced means for commun Federal, State triba	r communicating with the eral. State, tribal, regional, and anagement agencies. NT is not met as evidenced in the facility failed to include lures for primary and alternate sicating with facility staff, all regional, and local ement agencies in the			1) On 9/21/18 the Administrated and other members of the committee developed a perfor primary and alternate means of communicating facility staff during an emergency on 9/21/18.	· QAPI olicy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445234	B. WING			08/20/2018		
	(EACH DEFICIENC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160 ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)		.D BE	D BE COMPLETION	
	The finding include Interview on 08/20 2:40 PM, revealed polices and proces means for commulan emergency.	edness program per the ederal CFR §483.73. ed: /2018 between 1:55 PM and the facility had no record of dures for primary and alternate nicating with facility staff during erified by the administrator of the facility's emergency	E	032	 The QAPI committee will a policy on 9/21/18 during Committee meeting. Administrator in-serviced facility staff on 9/21/18 or policy that addresses a pri and alternate means of communicating with facility staff during an emergency facility will monitor for compliance by reviewing the disaster plan monthly during our QAPI meetings. The Administrator will repefindings of the audits monto the QAPI committee for follow up and recommendations as need for 3 months. The QAPI committee consist of Medical monto preventionist, Resident Financial Coordination Preventionist, Resident Financial Coordination Preventionist, Resident Records, Social Services, Plant Operations Manager, Activities and Discretized in the policy of the policy o	the in the imary ty . The che ing port athly r ded lical pont, urse/ mator, sions,	9/27/18	